

THERAPEUTIC LIVING SERVICES

Definition

The *Montana Medicaid Mental Health Clinical Management Guidelines* (referred to hereafter as the *Clinical Management Guidelines*) for Therapeutic Living defines these services as “out-of-home, community-based treatment alternatives appropriate for individuals requiring specific treatment interventions and/or social supports provided in a structured community environment.”

Therapeutic Living Services include: Therapeutic Youth Group Home (Moderate, Intensive, and Campus-based), Therapeutic Family Care (Moderate and Permanency). See **Definition of Terms**. Therapeutic Living Services for children and adolescents are provided by agencies licensed by the Department of Public Health and Human Services.

Prior Authorization Reviews

All Therapeutic Living services require prior authorization and must meet medical necessity guidelines as defined in the *Clinical Management Guidelines*. Refer to page TLS-15 of this section for the complete *Clinical Management Guidelines* specific to Therapeutic Living. Discussion of the Prior Authorization Review process begins on page TLS-3 of this section.

Continued Stay Review

All Therapeutic Living services that extend beyond the initial authorization date must be authorized through a Continued Stay review. Discussion of the Continued Stay Review process begins on page TLS-5 of this section.

Retrospective Review

Therapeutic Living Services are not subject to Retrospective Review by First Health Services of Montana except as requested by the Department of Public Health and Human Services, an individual or individual’s guardian or provider. This is discussed in detail under the **Retrospective Review** section.

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Discharge Procedure

Upon recipient discharge from any service for which prior authorization or continued stay reviews have been performed, the provider must complete a *Discharge Notification Form*. (See **FORMS** section of this manual.) This form must be submitted to First Health Services of Montana within five (5) business days after discharge. Admission approval/PA number cannot be issued until First Health Services of Montana has received a completed *Discharge Notification Form*.

PRIOR AUTHORIZATION PROCEDURE

Definition

Placement into Therapeutic Living Services begins with the recommendation of the Treatment Team for the least restrictive setting possible to meet clinical need. These services must be medically necessary and advantageous to the client, but not necessary to prevent death or disability and are considered as elective treatment. Therefore, prior authorization is required for all Therapeutic Living services.

Procedure

1. The provider must verify the recipient's Medicaid eligibility.
2. The provider should notify First Health Services of Montana as soon as the need for placement is determined, but **must** notify First Health Services of Montana at least 48 hours/two (2) business days prior to placement. This allows for timely completion of the prior authorization review process. This is a fax based notification process for submission of the request for prior authorization and pertinent information. (See FORMS section of this manual for *Prior Authorization Request Form*)
3. If the request is for Therapeutic Youth Group Home or Therapeutic Youth Family Care, the provider must submit a completed and valid CON (see **FORMS** section) at least 48 hours/two (2) business days prior to placement. See page TLS-7 of this section for additional information regarding the CON. All CONs for Youth Therapeutic Living Services require an additional signature of the intensive case manager employed by a mental health center (see ARM 37.86.2219, 37.86.2221).

NOTE: Reviews will not be completed until a valid CON is received.

A CON is required for all Therapeutic Living Services.

4. The provider must submit a prior authorization request form by fax that includes demographic and clinical information. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include:
 - Demographic information
 - Recipient's Medicaid ID number (MID) number
 - Recipient's Social Security Number (SSN)
 - Recipient's name, date of birth, sex

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Prior Authorization Procedure Continued:

- Recipient's address, county of eligibility, telephone number
 - Responsible party name, address, phone number
 - Provider name, provider number, planned date of placement
 - Clinical information
 - Prior inpatient treatment
 - Prior outpatient treatment/alternative treatment
 - Anticipated date of placement
 - Initial treatment plan
 - DSM IV diagnosis on Axis I through V
 - Medication history
 - Current symptoms/circumstances requiring Therapeutic Living Services
 - Chronic behavior/symptoms
 - Appropriate medical, social, and family histories
 - Proposed aftercare treatment
 - Completed CON (when applicable) as required in ARM 37.86.2219, 37.86.2221. See discussion regarding CON procedures and specific requirements (Pages TLS-7 through TLS-9 of this manual) for each service type and level.
6. Upon fax receipt of the above documentation, First Health Services of Montana's clinical reviewer will complete the review process as demonstrated in the *Prior Authorization Flow Chart* (Appendix A).
- The authorization review will be completed within two (2) business days from receipt of the review request and clinical information providing the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.
 - If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five (5) days of the request for additional information, and
 - The authorization review will be completed within two (2) business days from receipt of additional information
7. If medical necessity is met **and** the CON (if applicable) has been received at least 48 hours/two (2) business days prior to placement, the First Health Services of Montana reviewer will authorize placement and generate notification to all appropriate parties.
8. If medical necessity is not met, then the case is deferred to a Board-certified psychiatrist in the First Health National Clinical Review Center for review and determination.

CONTINUED STAY REVIEW PROCEDURE

Definition

A continued stay review is a review of currently delivered treatment to determine ongoing medical necessity for a continued level of care.

Reviews of requests for continued stay authorization are based on updated treatment plans, progress notes and recommendations of the individual's treatment team. Continued stay requests require prior authorization and must meet the medical necessity criteria as defined in the *Clinical Management Guidelines* for Therapeutic Living, Continued Stay Criteria.

Length of Stay

First Health Services of Montana will conduct continued stay reviews for all medically necessary stays in Therapeutic Living Services that extend beyond the number of days initially authorized. Each continued stay review may permit authorization of additional treatment when medical necessity is determined. Subsequent continued stay reviews will occur until the recipient is discharged from the facility or medical necessity is no longer met.

Procedure

1. The provider is responsible for contacting First Health Services of Montana by fax no more than 5 business days prior to the termination of the initial certification.
2. The provider must submit the following information to complete a continued stay review:
 - Changes to current DSM-IV diagnosis on Axis I through V
 - Justification for continued services at this level of care
 - Behavioral Management interventions/Critical Incidents
 - Assessment of treatment progress related to admitting symptoms and identified treatment goals
 - Current list of medications or rationale for medication changes, if applicable
 - Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan

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Continued Stay Review Procedure Continued:

3. Upon fax receipt of the above documentation, First Health Services of Montana's clinical reviewer will complete the review process as demonstrated in the *Continued Stay Flow Chart* (Appendix B).
 - The continued stay review will be completed within two (2) business days from receipt of the review request and clinical information providing the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.
 - If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five (5) days of the request for additional information, and
 - The continued stay review will be completed within two (2) business days from receipt of additional information
4. If medical necessity is met, the First Health Services of Montana reviewer will authorize the continued stay and generate notification to all appropriate parties.
5. If medical necessity is not met then the case is deferred to a Board-certified psychiatrist in the First Health National Clinical Review Center for review and determination.

CERTIFICATE OF NEED

Definition

A Certificate of Need (CON) is a state and Federal requirement (ARM 37.86.2219, 37.86.2221, CFR 441.152 and 441.153) for medical necessity documentation for Therapeutic Living Services for youth Medicaid recipients under age 21. CON requirements are specific to Therapeutic Youth Group Home and Therapeutic Family Care. *Prior authorization is not available for these services unless the provider submits to First Health of Montana a complete and accurate certificate of need.*

Therapeutic Youth Group Home/Therapeutic Family Care

The CON for Therapeutic Youth Group Home, as required in ARM 37.86.2219 and the CON for Therapeutic Family Care as required in ARM 37.86.2221 must: certify the necessary level of care.

The CON must certify that:

- a) Symptoms of the individual's emotional disturbance or mental illness are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service;
- b) The beneficiary exhibits behaviors related to the covered diagnosis that result in significant risk for psychiatric hospitalization or placement in a more restrictive environment if therapeutic living care is not provided or the person is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting;
- c) The prognosis for treatment of the individual's mental illness or emotional disturbance at a less restrictive level of care is very poor because the individual demonstrates 3 or more of the following due to the emotional disturbance or mental illness:
 - (i) significantly impaired interpersonal or social functioning;
 - (ii) significantly impaired educational or occupational functioning;
 - (iii) impairment of judgment; or
 - (iv) poor impulse control
- d) As a result of the emotional disturbance or mental illness, the individual exhibits an inability to perform daily living activities in a developmentally appropriate manner;
- e) As a result of the emotional disturbance or mental illness, the beneficiary exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

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Certificate of Need Continued:

As established in ARM 37.86.2219(3) and 37.86.2221(3), the CON for recipients determined Medicaid/MHSP eligible as of the time of admission to the Therapeutic Group Home/Therapeutic Family Care must:

- a. Be completed, signed, and dated prior to, but no more than 30 days before, admission; and
- b. Be made by a team of health care professionals that has competence in diagnosis and treatment of mental illness, and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include:
 - a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry;
 - a licensed mental health professional; and
 - an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department

No more than one member of the team of health care professionals may be professionally or financially associated with a therapeutic youth group home program/therapeutic family care program.

As set forth in ARM 37.86.2219(5) and 37.86.2221(5), all required CONs must actually and personally be signed by each team member, except that the signature stamps may be used if the treatment team actually and personally initials the document over the signature stamp.

NOTE: When a recipient is determined Medicaid eligible as of the time of admission, reviews will not be completed until a valid CON is received.

However, as established in ARM 37.86.2219(4) and 37.86.2221(4), the CON for recipients determined Medicaid/MHSP eligible after admission to or discharge from the Therapeutic Group Home/Therapeutic Family Care is waived. A retrospective review to determine the medical necessity of the admission to the program and the treatment provided will be completed at the request of the Department, a provider, the individual, or the individual's parent or guardian. (See **Request for Retrospective Review** following.)

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Certificate of Need Continued:

Request for Retrospective Review (when CON has been waived)

The following discussion applies to only those services and circumstances for which a CON has been waived and the Department, a provider, the individual, or the individual's parent or guardian requests a retrospective review to determine the medical necessity of the admission to the program and the treatment provided. This request for retrospective review **IS NOT** applicable to retrospective reviews that will be routinely conducted on a sample basis across various services.

In the event, as described above, that the Department, a provider, the individual, or the individual's parent or guardian requests a retrospective review, the request for retrospective review must:

- a. Be received by First Health of Montana within 14 days after the eligibility determination for recipients determined eligible following admission, but before discharge from the Therapeutic Youth Group Home/Therapeutic Family Care, or
- b. Be received by First Health of Montana within 90 days after the eligibility determination for recipients determined eligible after discharge from the Therapeutic Youth Group Home/Therapeutic Family Care

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DETERMINATIONS

Upon completion of the review, one of the following determinations will be applied and notification will be made as outlined in **Notification Process** of this section:

1) **Authorization:**

An authorization determination indicates that utilization review resulted in approval of all provider requested services and /or service units and a prior authorization number is issued.

2) **Pending Authorization:**

Indicates that a First Health Services of Montana reviewer or First Health psychiatrist has requested additional information from the provider. The provider will have five (5) days to provide any additional information needed to make a payment determination.

3) **Partial Approval:**

Partial approval is considered an adverse payment determination indicating that the request does not meet the appropriate Medicaid criteria to justify Medicaid payments for the level or complete duration of services requested. Only a First Health psychiatrist may issue a partial approval. Partial approvals are subject to the First Health Services of Montana Appeal process.

4) **Denial:**

The request for authorization of payment does not meet the appropriate Medicaid medical necessity criteria to justify Medicaid payment for the services requested. Authorization for payment is denied. Only a First Health psychiatrist may issue a denial. Denials are subject to the First Health Services of Montana Appeal process.

5) **Technical Denial (Administrative Denial):**

A prior authorization review was not administered on medical necessity criteria as a result of provider Medicaid protocol non-compliance. Non-compliance indicates that the request and/or information was out of specified timeframes or was incomplete. Technical denials may be appealed to the Children's Mental Health Bureau within 30 days of date of notification.

NOTE: The ARM specifically states, "An authorization by the department of its utilization review under this rule is not final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the medical necessity of services or items at any time."

NOTIFICATION PROCESS

First Health Services of Montana recognizes the importance of prompt notification of all relevant parties with regard to authorizations and denials. “Relevant parties” is defined as beneficiaries, families or guardians of recipients, requesting providers, and the Department. When appropriate, First Health Services of Montana will notify the regional care coordinator to assist in the transition to other levels of care.

First Health Services of Montana will implement a two-step notification process, providing both informal and formal notification.

Informal Notification

Informal notification will be completed via facsimile on a daily basis and will include:

- Outcome report to the Department of all determinations, regardless of region or provider
- Outcome report of all determinations will be given to each provider (Provider specific information only)
- Outcome report of all determinations will be provided to the regional care coordinator (region specific only)

The above outcome reports are generated and transmitted via facsimile by 9:00 AM Mountain Time on the next business day.

Formal Notification

Formal notification will be made providing all relevant parties with a hardcopy determination sent by US mail.

- Authorization and continued stay determinations will be mailed by regular US mail
- Denial determinations (technical denials or denial for medically unnecessary) will be mailed certified return receipt mail and tracked to ensure delivery

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Notification Process Continued:

- Notifications for technical denial determinations will include:
 - Dates of service that are denied a payment because of noncompliance with Administrative Rule
 - Reference applicable federal and/or state regulations
 - An explanation of the right of the parties to request an Appeal
 - Name and address of the person to contact to request an Appeal
 - A brief statement of First Health Services of Montana's contractual responsibility to the State of Montana for utilization reviews
- Notifications for denial determinations for medically unnecessary treatment/services will include:
 - Dates of service that are denied a payment recommendation because the services in question are considered medically unnecessary according to Medicaid/MHSP criteria or protocols
 - Case specific denial rationale based on the medical necessity criteria upon which the determination was made
 - Reference federal and/or state regulations governing the review process
 - Date of notice of First Health Services of Montana's decision which is the date of printing and mailing; and/or the date of the confirmed facsimile transmission
 - An explanation of the right of the recipient (or legal guardian), the psychiatrist/physician, and/or the provider to request an Appeal
 - Name and address of person or office to contact to request an Appeal
 - A brief statement of First Health Services of Montana's contractual responsibility to the State of Montana for utilization reviews

**FIRST HEALTH SERVICES OF MONTANA
APPEAL PROCESS**

Definition

Appeal—Consumer, provider, or agent’s challenge of a denial. Appeal may be indicated through the use of any one of the following terms: Appeal, Administrative Review, Reconsideration, or Fair Hearing.

Process

All adverse determinations are made by Board-certified psychiatrists. Our review process is designed to take advantage of the Montana-specific knowledge of treatment availability, access, and program strengths that our Montana physician panel brings to the determination process. Therefore, First Health Services of Montana will defer appeals to a Montana-based physician for final determination whenever possible. However, First Health employs a sufficient number of psychiatrists certified by the American Board of Psychiatry and Neurology so that all appeal determinations will be completed by a psychiatrist not involved in the original adverse determination. This process allows for a choice of a peer-to-peer or a desk based review using the following process:

- a. Upon receipt of an adverse determination, the recipient or recipient’s guardian or the provider/facility may request an appeal of the adverse determination.
- b. The request for appeal must be received at the First Health Services of Montana, Helena office within 30 days of the date of receipt of the determination notice.
- c. The request for appeal must specify the option of peer discussion/review or desk review. Any additional information to be considered must be included with the request.

Peer-to-Peer Discussion/Review:

Scheduling of peer reviews must be requested and coordinated through the First Health Services of Montana, Helena office. To permit completion of the appeal process within five (5) business days of receipt of the request, the peer-to-peer discussion will be completed within 72 hours/three (3) business days of receipt of the request.

Desk Review:

A desk review will be performed whenever a peer review has not been requested or when the request for appeal does not specify peer discussion or desk review.

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Appeal Process Continued:

- d. First Health Services of Montana completes the appeal review within five (5) business days of the receipt of the request. A Board-certified psychiatrist, who has no prior knowledge of the case or professional relationship or ties with the provider, completes the reconsideration review. Whenever possible, Montana licensed and based Board-certified psychiatrists will complete these reviews.
- e. All final determinations include rationale for the determination based upon the applicable federal and state regulations, and include instructions as to the rights of further appeal.
- f. The determination rendered by the appellate physician performing the review will, in all cases, stand as the final First Health Services of Montana decision.
- g. If the appeal review upholds the adverse determination, the rights of the provider and/or the beneficiary to an administrative review or reconsideration with the Montana Department of Public Health and Human Services will be included in the formal notification. First Health Board-certified psychiatrists and licensed psychologists provide input regarding the determination rationale, application of federal and state regulations, and other relevant information.

Please refer to Appendix C for the First Health of Montana Appeals Process.

THERAPEUTIC LIVING CLINICAL MANAGEMENT GUIDELINES

First Health Services of Montana will employ the use of *the Montana Medicaid Clinical Management Guidelines* strictly as guidelines. This practical application, coupled with professional judgement based on clinical expertise and national best practices, will enhance the authorization decisions.

Mental Health Therapeutic Living represents community-based treatment alternatives, which include, but are not limited to, therapeutic group homes and therapeutic foster/family care. Therapeutic Living Services are appropriate for individuals requiring specific treatment interventions and/or social supports. The person requires a higher intensity of, and accessibility to, therapeutic interventions than are available through traditional outpatient services and which clearly exceed the capabilities of immediate family, relatives, friends, or other community systems. The supportive environments provided in Therapeutic Living are based on active treatment interventions that are provided in accordance with the person's individual treatment plan (ITP). Such interventions, guided by the treatment team, are provided by clinical staff or by specially trained staff under the supervision of clinical staff. The ITP is developed by the treatment team, including the person and family, if appropriate, and specifies treatment, behavioral interventions, and supports which are designed and applied to result in the person's discharge to a less restrictive environment.

This level of treatment intervention includes a consideration of the person's safety and security needs and the degree of self-care skills demonstrated by the person. This includes the ability and likelihood of the person to benefit from a community integrated program.

Therapeutic Living Services for children and adolescents must be provided by an agency that is licensed by and contracted with the Department of Public Health and Human services. Intensive and moderate therapeutic family care may be provided within a foster home or the youth's natural or adoptive home. Permanency therapeutic family care is intensive family care for which the foster family placement has a likelihood of becoming permanent.

Therapeutic Living Services for adults are provided by a licensed mental health center with an endorsement to provide adult foster or group home care.

Admission Criteria

A request for authorization for therapeutic living must include a recommendation by the individual's treatment team for the least restrictive setting appropriate for the clinical need. The following criteria must be met for placement:

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1. A covered DSM-IV diagnosis as the principal diagnosis and identification of the person as having a serious emotional disturbance or a severe disabling mental illness.
AND
2. A child or adolescent must meet at least *three* of the criteria below for Moderate or Campus Based Therapeutic Living and *four* of the criteria below for Intensive Therapeutic Living Services. An adult must meet at least *three* of the criteria below for therapeutic living.
 - a. Symptoms of the individual's emotional disturbance or mental illness are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service. Out patient interventions have been attempted and have been documented to be insufficient to meet the client's needs and safety concerns.
 - b. The beneficiary exhibits behaviors related to the covered diagnosis that result in significant risk for psychiatric hospitalization or placement in a more restrictive environment if therapeutic living care is not provided, or the person is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting,
 - c. The prognosis for treatment of the individual's mental illness or emotional disturbance at a less restrictive level of care is very poor because there is documentation the beneficiary demonstrates *three* or more of the following due to the emotional disturbance or mental illness:
 1. Significantly impaired interpersonal and-or social functioning,
 2. Significantly impaired educational and/or occupational functioning,
 3. Impairment of judgement,
 4. Poor impulse control
 - d. As a result of the emotional disturbance or mental illness, the individual exhibits an inability to perform daily living activities in a developmentally appropriate manner.
3. There is a comprehensive and viable discharge plan with an estimated length of stay.

Continued Stay Criteria (Must meet all the following):

1. The individual must continue to meet all of the Admission Criteria. In addition, all of the following criteria must be met:
2. Demonstrated progress toward identified treatment goals and the reasonable likelihood of continued progress.
3. The beneficiary and family, when appropriate, are engaged in treatment and making progress toward treatment goals.
4. The beneficiary's symptoms do not require a more intensive level of care but have demonstrated they are severe enough that a less intensive level of care would be insufficient to meet treatment needs.
5. Demonstrated and documented progress is being made on the comprehensive discharge plan. The Treatment Team provides a clinical rationale for any recommended changes in the discharge plan or anticipated discharge date.

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Discharge Criteria

1. The Individual Treatment Plan goals have been sufficiently met such that the person no longer requires this level of care.
OR
2. The beneficiary voluntarily leaves the program or the beneficiary's parent or legal guardian removes them from the program.